0000 27 9216

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OHIO DEPARTMENT OF HEALTH (ODH)
CHOOSE LIFE FUND
DISTRIBUTION APPLICATION

Interested Organizations: This application is due by June 1, 2016. Use this form to apply for SFY17 (July 1, 2016 to June 30, 2017) Choose Life Funds available for your county and for funds that may be available for contiguous counties. It is important that you completely fill in the requested information and include all other required documentation. An application will only be considered when all required documents and information has been provided by the deadline.

I. ODH and Organization Information.

Organization	CLEVELAND PREGNANCY CENTER
Federal Tax ID Number	[redacted]
Street Address	5273 BROADVIEW RD
City, State Zip code	CLEVELAND, OH 44134
County of Location Providing Services *(One Application Per Location)*	CUYAHOGA
Address where ODH should Direct Payment	5273 BROADVIEW RD CLEVELAND, OH 44134
Counties of Service *This location serves women from the following counties:*	[ ] CUYAHOGA
Name of Person and Title completing application	JENNY PETEK
Area Code/Phone Number	216.631.0964
Email	DIRECTOR@CLEVELANDPREGNANCYCENTER.ORG

II. By submitting this Application to ODH, Organization agrees to adhere to the statutory requirements for activities and use of funds as outlined in Ohio Revised Code (RC) 3701.65 and rules under Ohio Administrative Code (OAC) 3701-74-01, and I certify that the Organization:

A. Is eligible to receive Choose Life Funds as described in RC 3701.65 and OAC 3701-74-01;

B. Is a private, nonprofit organization;

C. Is committed to counseling pregnant women about the option of adoption;

D. Provides services within the state of Ohio to pregnant women who are planning to place their children for adoption, including counseling and meeting the material needs of the women;

E. Does not charge pregnant women for any services received;

F. Is not involved or associated with any abortion activities, including counseling for or referrals to abortion clinics, providing medical abortion-related procedures, or pro-abortion advertising;

G. Does not discriminate in its provision of any service on the basis of race, religion, color, marital status, national origin, handicap, gender or age.

III. **Funding available in contiguous and noncontiguous counties:** Organizations may apply for Choose Life funds that may be available in contiguous and noncontiguous counties. The Organization must certify, by signing the application, that it provides services to pregnant women residing in those counties that are listed in Section I of this application. Organization is eligible to receive Choose Life funds from the counties listed in Section I of this application if there are no eligible organization located within those counties.

IV. **For Current Choose Life Organizations:** By June 1, 2016, you must submit the following with this Application:

A. One (1) of the following three (3) forms of reporting for the previous year (June 1, 2015 to May 31, 2016) ("Acceptable Form of Reporting"), which will be incorporated into the terms of this Application:

1. An Audited Financial Statement. This audited financial statement is required if Organization traditionally has an audited financial statement that is available at the time of application. The audited financial statement must be prepared by an independent Certified Public Accountant (CPA). The CPA should be familiar with acceptable standards. Statements must verify that the Choose Life funds were used as follows:

a) Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;

b) Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;

c) None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or

2. Notarized Financial Statement Form. This form of reporting may be used if the organization does not traditionally have an audited financial statement and to have one would create a hardship. The statement must verify that the Choose Life Funds were used as follows:

a) Not more than sixty percent (60%) of the funds were used for the material needs of pregnant women who are planning to place their children for adoption or for the infants awaiting placement with adoptive parents, including clothing, housing, medical care, food, utilities, and transportation;

b) Not more than forty percent (40%) of the funds were used for counseling, training, or advertising;

c) None of the funds were used for administrative expenses, legal expenses, or capital expenditures; or,

3. Expenditure Tracking Form. This form of reporting may be used if Organization does not traditionally have an audited financial statement and a financial statement is not available at the time of application. This form may be found on the ODH website or available upon request; *and*,

4. A new *Supplier Information Form*. (if Organization has moved).

   In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form.

All applicable forms can be found at:

http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx

Assistance in completing the form(s) can be obtained directly from Ohio Shared Services by calling: 1(877) OHIO-SS1, (1-877-644-6771), or 1 (614) 338-4781.

V. **For New Choose Life Organization Applicants:** By June 1, 2016 submit the following:

- One (1) original, signed *W-9* form per Organization. If your Organization has multiple locations, please choose the location where you would prefer a check to be mailed.

  In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form; and

- Completed *Supplier Information Form*

  In addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form; and

- Completed *Authorization Agreement for Direct Deposit of EFT Payments* form (*optional*).

  If the Organization elects EFT payments over paper check payments, then in addition to returning the form with this application, the Organization will also be required to fax, email, or mail the form directly to Ohio Shared Services as directed at the bottom of the form.

All applicable forms can be found at:

http://ohiosharedservices.ohio.gov/SupplierOperations/Forms.aspx

Assistance in completing the form(s) can be obtained directly from Ohio Shared Services by calling: 1(877) OHIO-SS1, (1-877-644-6771), or 1 (614) 338-4781.

VI. ***By June 1, 2017, all Organizations*** shall submit to ODH one of the three forms of reporting from Section III, above, verifying compliance with the rules regarding the use of funds received during the year (June 1, 2016–May 30, 2017).

By my signature, I certify that I have the authority to act on behalf of the above-named Organization and that the information provided in this Application is true and accurate to my knowledge and belief. Further, by my signature, I acknowledge that I understand and Organization agrees that in accepting Choose Life Funds, Organization must comply with the terms and conditions of RC 3701.65 as set forth in this Application for the state fiscal year of 2017 or risk the forfeiture of and be obliged to return said Choose Life Funds in the event Organization does not conduct itself in the manner prescribed above.

May 24, 2016
Date

Gerald P. Petek
Signature of Person Completing Application

Gerald Petek Acting Ex. Dir. / Trustee
[Print Name & Title]

Application to be submitted to:

Ohio Department of Health
Bureau of Maternal and Child Health
246 North High Street, 6th floor
Columbus, OH 43215
Attention: Marius Igwe

Phone: 614.466.4634
Email: Marius.Igwe@odh.ohio.gov

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
Cleveland Pregnancy Center

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only one of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☒ Other (see instructions) ▶ See attached 501(C)(3)

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)
5273 Broadview Rd.

Requester's name and address (optional)

6 City, state, and ZIP code
Parma, Ohio 44134

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

or

Employer identification number
[redacted]

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here Signature of U.S. person ▶ _____ Date ▶ _____

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Ohio | Department of Taxation

tax.ohio.gov

STEC U
Rev. 3/15

Sales and Use Tax
Unit Exemption Certificate

The purchaser hereby claims exception or exemption on all purchases of tangible personal property and selected services made under this certificate from:

Cleveland Pregnancy Center Inc.

(Vendor's name)

and certifies that the claim is based upon the purchaser's proposed use of the items or services, the activity of the purchase, or both, as shown hereon:

Non-Profit 501(c)(3) Organization

Purchaser must state a valid reason for claiming exception or exemption.

Cleveland Pregnancy Center Inc.
Purchaser's name

Pregnancy Resource Center
Purchaser's type of business

5273 Broadview Rd.
Street address

Parma, Ohio 44134
City, state, ZIP code

Executive Director
Signature — Title

6.9.16
Date signed

[redacted]
Vendor's license number, if any

Vendors of motor vehicles, titled watercraft and titled outboard motors may use this certificate to purchase these items under the "resale" exception. Otherwise, purchaser must comply with either Administrative Code Rule 5703-9-10 or 5703-9-25.

This certificate cannot be used by construction contractors to purchase material for incorporation into real property under an exempt construction contract. Construction contractors must comply with Administrative Code Rule 5703-9-14.

Please review the instructions available on page 2 prior to completing this form.

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF EFT PAYMENTS

SECTION 1: CONTACT INFORMATION

TAX IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) [redacted]

Please note: We are required to obtain your Tax Identification Number pursuant to Section 6109 of the Internal Revenue Code so that we can report income paid to you to the IRS as required by law.

NAME OF COMPANY OR INDIVIDUAL

NAME: Cleveland Pregnancy Center

ADDRESS

STREET: 5273 Broadview Rd.

SUITE / ROOM #:

CITY: Parma **STATE:** OH **ZIP CODE:** 44134

PHONE: 216.631.0964

EMAIL ADDRESS: director@clevelandpregnancycenter.org

TYPE OF TRANSACTION

- ☐ ADD
- ☐ CHANGE/UPDATE
- ☐ INACTIVATE

CHOOSE THE STATE AGENCY FROM WHICH YOU ARE BEING REIMBURSED

- ☐ DODD
- ☐ OOD/PCA
- ☐ LOTTERY WINNER
- ☒ ALL OTHER

☐ **MEDICAID PROVIDER** (PROVIDER#, NPI#, ASSIGNING AUTHORITY required)

PROVIDER #

NPI #

ASSIGNING AUTHORITY

SECTION 2: NEW FINANCIAL INFORMATION

BANK VERIFICATION MUST BE ATTACHED

NEW FINANCIAL INSTITUTION NAME: First Merit Bank

ACCOUNT TYPE ☒ CHECKING ☐ SAVINGS

NEW ACCOUNT NUMBER [redacted]

Account Number supplied must match attached bank verification

NEW TRANSIT ROUTING /ABA NUMBER [redacted]

Routing Number supplied must match attached bank verification

SECTION 3: PRIOR FINANCIAL INFORMATION

MUST BE PROVIDED TO CHANGE/UPDATE ACCOUNT

PRIOR FINANCIAL INSTITUTION NAME

PRIOR ACCOUNT NUMBER

Account Number supplied must match previous Account Number on file

PRIOR TRANSIT ROUTING /ABA NUMBER

Routing Number supplied must match previous Routing Number on file

SECTION 4: READ THE AGREEMENT, SIGN, & DATE DIGITAL/TYPED AND STAMPED SIGNATURES ARE NOT ACCEPTED AT THIS TIME

- Account changes must be reported to Ohio Shared Services (OSS) thirty (30) days prior to the effective date.
- All EFT accounts are tied to an address in our system, a form is required for each address (if needed)
- The entity listed hereby authorizes the Ohio Office of Budget and Management (OBM) to initiate credit entries to its account in the financial institution identified above. Additionally, this form provides OBM the authority to debit any erroneous credit or transfers to the account in the amount of the transfer. This authority is to remain in effect until revoked by us in writing to OSS, a division of OBM.

☒ **I have attached a copy of a current voided check or included a bank letter on bank letterhead signed by a bank representative.**

☐ **Medicaid PROVIDERS – I have ensured the Name, Address, TIN, NPI# & Provider Number matches the information in the MITS Medicaid Web Portal.**

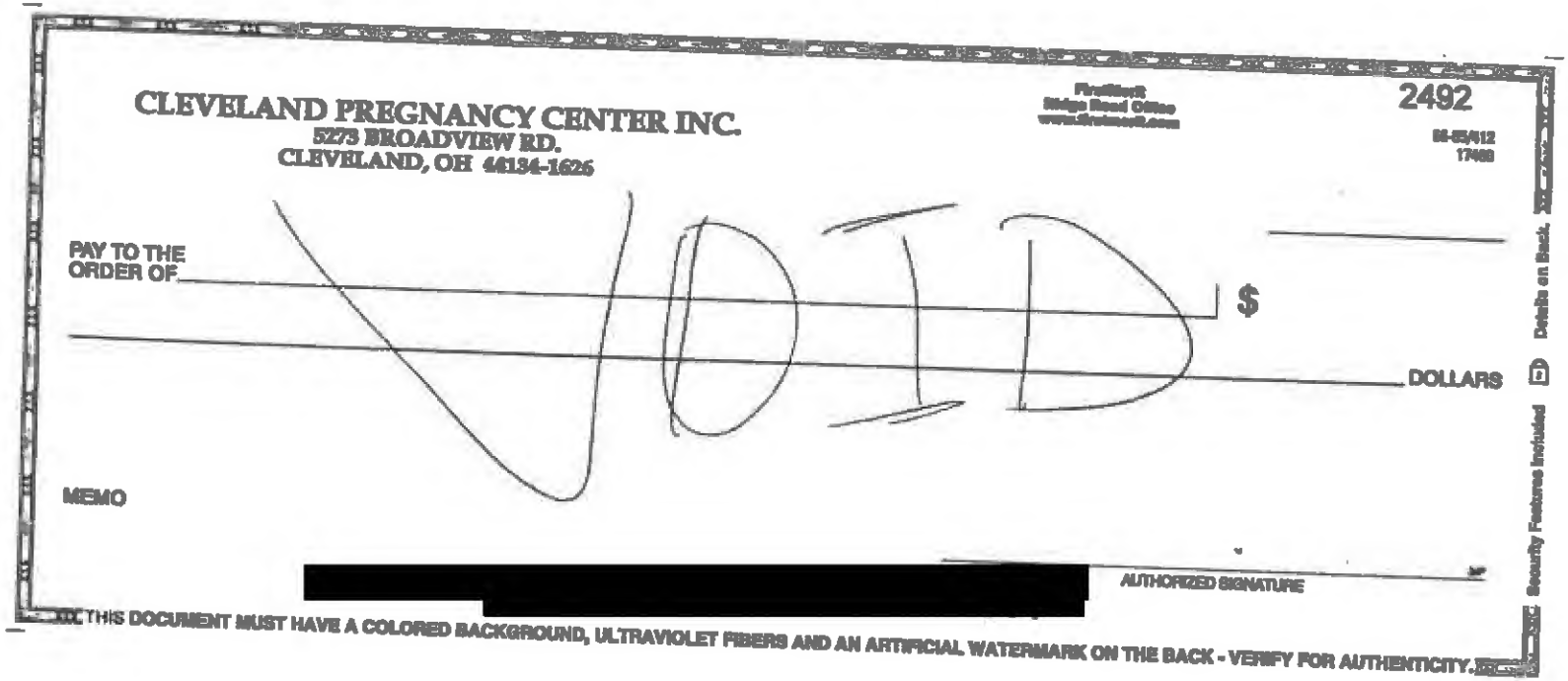
☒ **I have printed and signed the form.**

X Robert A. Hersley | Robert A. Hersley | 6.18.16

SIGN YOUR NAME HERE | PRINT YOUR NAME HERE | DATE

Select one of the following methods to submit this form:

E-mail	Mail	Fax
supplier@ohio.gov	Ohio Shared Services, Attn: Supplier Operations P O Box 182880 Columbus, OH 43218-2880	1-614-485-1052


CLEVELAND PREGNANCY CENTER INC.
5273 BROADVIEW RD.
CLEVELAND, OH 44134-1626
2492
PAY TO THE ORDER OF
$
VOID
DOLLARS
MEMO
[redacted]
AUTHORIZED SIGNATURE
THIS DOCUMENT MUST HAVE A COLORED BACKGROUND, ULTRAVIOLET FIBERS AND AN ARTIFICIAL WATERMARK ON THE BACK - VERIFY FOR AUTHENTICITY.
Details on Back.
Security Features Included

hi

SUPPLIER INFORMATION FORM

Required sections must be completed or the form will not be processed. Incomplete forms will be returned. All information must be legible. Ensure this is the latest version of the form at www.ohiosharedservices.ohio.gov.

SECTION 1 – PLEASE SPECIFY TYPE OF ACTION (REQUIRED)

☒ NEW (W-9 OR W-8ECI FORM ATTACHED) ☐ CHANGE OF CONTACT PERSON/INFORMATON

☐ ADDITIONAL ADDRESS

☐ CHANGE OF ADDRESS – (PLEASE PROVIDE OLD ADDRESS BELOW OR ATTACH LETTER)

ADDRESS TO BE REPLACED:

☐ CHANGE OF TIN (W-9 & A CHANGE OF TIN FORM ☐ CHANGE OF NAME (W-9 & A CHANGE OF NAME FORM)

☐ CHANGE OF PAY TERMS ☐ CHANGE OF PO DISPATCH METHOD ☐ OTHER_____

SECTION 2 – PLEASE PROVIDE SUPPLIER INFORMATION (REQUIRED)

LEGAL BUSINESS OR INDIVIDUAL NAME: (MUST MATCH W-9 OR W-8ECI FORM)
Cleveland Pregnancy Center

BUSINESS NAME, TRADE NAME, DOING BUSINESS AS: (IF DIFFERENT THAN ABOVE)

FEDERAL EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (ssn)[1] : [redacted]

SECTION 3 – REMIT TO ADDRESS (REQUIRED)

ADDRESS: 5273 Broadview Rd. | COUNTY: Cuyahoga

ADDRESS (CONT.):

CITY: Parma | STATE: Ohio | ZIP CODE: 44134

CONTACT NAME: Bob Hershey

PHONE: 216-631-0964 | FAX: | E-MAIL: director@clevelandpregnancycenter.org

SECTION 4 – ADDITIONAL ADDRESS (IF MORE THAN 2 ADDRESSES, INCLUDE A SEPARATE SHEET)

ADDRESS: | COUNTY:

ADDRESS (CONT.):

CITY: | STATE: | ZIP CODE:

SECTION 5 – CONTACT PERSON TO RECEIVE E-MAIL NOTICE OF BID EVENTS - A USER ID & PASSWORD WILL BE SENT TO THE E-MAIL ADDRESS BELOW – (BUSINESSES ONLY)

NAME: Bob Hershey

E-MAIL: director@clevelandpregnancycenter.org

TO ADD AN ADDITITIONAL OR TO REPLACE THE CURRENT STRATEGIC SOURCING (SS) CONTACT

☐ **ADDITIONAL STRATEGIC SOURCING CONTACT** ☐ **REPLACE SS CONTACT (WILL BE MARKED INACTIVE)**

NAME:

E-MAIL:

SECTION 6 – PAYMENT TERMS (PLEASE CHECK ONE – IF NONE IS SELECTED THEN NET 30 WILL APPLY
Invoices will be paid in 30 days from invoice date unless an alternate pay-term is selected below

☐ **2/10 NET 30** ☒ **NET 30**

SECTION 7 – PURCHASE ORDER DISTRIBUTION–OTHER THAN USPS MAIL (ONLY APPLICABLE TO THOSE RECEIVING POs)

E-MAIL OR FAX:

SECTION 8 – PLEASE SIGN & DATE (REQUIRED)

PRINT NAME: Robert A. Hershey

SIGNATURE: (HANDWRITTEN SIGNATURE REQUIRED) Robt A. Hersh

DATE: 6.18.16

SECTION 9 – STATE OF OHIO AGENCY CONTACT PERSON (AGENCY RECEIVING PAYMENTS FROM)

AGENCY CONTACT NAME/E-MAIL/PHONE: Marivs Igwe Marivs.Igwe@odh.ohio.gov 614-466-4634

COMMENTS:

Note: This document contains sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk.
[1] Pursuant to 26 USC 6109, the state is required to collect TIN/EIN/Social Security numbers and to use the numbers in its annual report to the IRS the amount the state has paid each supplier.

SELECT ONE OF THE FOLLOWING METHODS FOR DOCUMENT SUBMISSION:

Email: supplier@ohio.gov
Fax: 1 (614) 485-1052
Mail: Ohio Shared Services
Attn: Supplier Operations
P.O. Box 182880 Cols., OH 43218-2880

QUESTIONS? PLEASE CONTACT:

Phone: 1 (877) OHIO - SS1 (1-877-644-6771)
1 (614) 338-4781
Website: www.ohiosharedservices.ohio.gov
Email: supplier@ohio.gov

Purchase Order

Payment Provision: The purchase order number authorizing the delivery of products or services MUST be included on the invoice.

Dept of Health

Supplier:
0000239216
CLEVELAND PREGNANCY CENTER
5273 BROADVIEW RD
PARMA OH 44134

Dispatch via Print

Purchase Order	Date	Revision	Page
DOH01-0000045597	08/30/2016		1
Payment Terms	**Freight Terms**		**Ship Via**
Net 30	FOB Destination, Prepaid		N/A
	Phone		**Currency**
KENNON A HUGHES			USD

Ship To: Dept of Health
P003574
KENNON A HUGHES
P.O. Box 118
(614) 466-3543
Columbus OH 43216-0118
United States

Bill To: Dept of Health
P.O. Box 118
(614) 466-3543
Columbus OH 43216-0118
United States

Line-Sch	Quantity	UOM		Unit Price	Extended Amt	Due Date
1- 1	1	AMT	Choose Life Program	3,420	3,420.00	

Schedule Total 3,420.00

Item Total 3,420.00

ODH Contact: Marius Igwe 614-466-4634 Contract# 8065

Total PO Amount 3,420.00

The Director of Budget and Management certifies that there is a balance available in the appropriation not already obligated to pay existing obligations in an amount at least equal to the portion of the contract, agreement, obligation resolution or order to be performed in the current fiscal year.

Department Head
Richard Hodges, MPA
Director of Health

By accepting this purchase order, Vendor hereby certifies that it is in full compliance with ORC Section 3517.13 as it relates to campaign finance contributions.

INVOICE

Invoice #: 0118
Invoice Date: 09/23/2016
Purchase Order #: **DOH01-0000045597**
OAKS Vendor #: 0000239216

Bill To: Ohio Department of Health
Bureau of Maternal, Child and Family Health
P.O. Box 118
Columbus, Ohio 43216

Remit To: Cleveland Pregnancy Center
5273 Broadview Road
Parma, Ohio 44134

Quantity	Description	Unit Cost	Amount
1	Provision of Choose Life services for women who are considering adoption.	1	$3,420.00

Program Approval: [signature]
Approval Date: 9/23/16 at 4pm

Grand Total $3,420.00

OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

John R. Kasich/Governor

Richard Hodges/Director of Health

Jerry Petek
Cleveland Pregnancy Center
5273 Broadview Road
Cleveland, OH 44134

Tax ID: [redacted]

Dear Mr. Petek:

Thank you for your interest in the Choose Life Program and for your application for the Choose Life funding. Application(s) was approved for the following county(s) in the amount(s) of:

- Cuyahoga $ 3,420.00

Enclosed is a copy of the contract as was submitted. You should receive an award totaling $3,420.00 within the next 30 days.

If you have any questions, please contact the Choose Life Program consultant, Marius Igwe, at Marius.Igwe@odh.ohio.gov or phone 614-466-4634.

Sincerely,

Richard Hodges, MPA
Director of Health